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Facilitators and inhibitors of transition for older people who have relocated to a long-term care facility: a systematic review

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Author Contribution

JF wrote the review protocol. VT conducted the searches and contributed to screening, data extraction and synthesis. JF led on screening, data extraction and synthesis. Both authors reviewed and edited drafts of the manuscript and approved the final manuscript.

Facilitators and inhibitors of transition for older people who have relocated to a long-term care facility: a systematic review

Abstract

Moving into a long-term care facility to live permanently is a significant life event for older people. Care facilities need to support older people to make a healthy transition following relocation. To help achieve this we need to understand what facilitates and inhibits the transition process from the perspective of older people, their families, and care facility staff. Our review generated new knowledge to inform this understanding. We addressed the question: what factors facilitate and inhibit transition for older people who have relocated to a long-term care facility? Five electronic databases PsychINFO, British Nursing Index, CINAHL, MEDLINE, and Web of Science were searched for the period January 1990 to October 2017. Grey literature searches were conducted using Google Scholar, and Social Science Research Network. Data were extracted for individual studies and a narrative synthesis was conducted informed by Meleis's Theory of Transition. 34 studies (25 qualitative, 7 quantitative and 2 mixed methods) met the inclusion criteria. Data synthesis identified that transition following relocation was examined using a variety of terms, timelines, and study designs. Potential personal and community focused facilitators and inhibitors mapped to four themes: resilience of the older person, interpersonal connections and relationships, this is my new home, and the care facility as an organisation. These findings can inform the development of interventions for these target areas. They highlight also that further research is warranted to understand the organisational culture of long-term care facilities, how this influences transition, and how it might be shaped to create and sustain a caring culture for older people.

Keywords: older people, long-term care, care homes, transition, systematic review.

What is known about the topic?

- Relocation to a long-term care facility is a significant life event with potential psychological and physiological consequences for older people.
- Transition is facilitated by factors such as retaining personal possessions, relationships, and person-centred care.
- There are no known systematic reviews that identify facilitators and inhibitors from the perspective of older people, families, and staff.

What this paper adds

- Identifies personal and community focused facilitators and inhibitors to inform the development of interventions to facilitate older people's transition.
- Shows that research studies use a multiplicity of terms and concepts, are of varied methodological quality, and few are theoretically framed.
- Highlights the potential influence of organisational culture for transition.

Introduction

Transition is defined as a "passage from one life phase, condition or status to another, a multiple concept embracing the elements of process, time span, and perception" (Chick & Meleis 2010 pp25-26). Meleis et al (2010) proposed that there are several types of transition including situational, developmental, and health and illness, and that more than one may be experienced concurrently. We used Meleis's conceptualisation of transition to inform our review; our focus is older people experiencing a situational transition following their relocation to a long-term care facility as a permanent arrangement.

Relocation to a long-term care facility is a significant life event for an older person, with the potential to be stressful and with negative psychological and physiological outcomes (Schulz & Brenner 1977, Castle 2001). A desired outcome of relocation is a healthy transition, that is, personal stability or progress towards achieving this (Meleis et al, 2010). A healthy transition is characterised by response patterns, that is, process indicators such as feeling connected, interacting, and developing confidence and coping, and by outcome indicators such as well-being, mastery of new roles, and the well-being of interpersonal relationships (Schumacher & Meleis 1994, Meleis et al 2010). Facilitating or inhibiting the process are transition conditions, that is, personal conditions (e.g. meanings, cultural beliefs and attitudes, preparation and knowledge), community conditions (e.g. support from family and community networks), and societal conditions (e.g. how a society views older people and long-term care facilities). Davies (2005) investigated support for Meleis's theory in her United Kingdom study exploring relatives' (n=48) experiences of older people's relocation to a nursing home (n=3). Davies reported that all domains of the theory were supported although she identified limitations, namely, that it did not consider fully the nature of inter-relationships between key stakeholders, treating "recipients of nursing interventions as

passive, with little potential to contribute to their environment or influence their own destiny" (Davies 2005, p664), and that it emphasises insufficiently the significance of organisational culture within nursing homes for the experiences of service users.

Currently there are approximately 421,000 people aged 65 years and over living in UK nursing and residential care (Age UK (a) 2017). There are over 10,500 care homes in the UK (approximately 4,699 nursing homes and 6,023 residential homes without nursing Age UK 2017(a)). Predictors of entry to long-term care facilities include functional and cognitive impairment (Gaugler et al 2007, Luppa et al 2010), prior nursing home placement (Gaugler et al 2007), and lack of support and assistance with daily living (Luppa et al 2010). It is expected that demands for long-term care will grow because of such factors, coupled with demographic ageing worldwide (Wittenberg et al 2004, Hussein and Manthorpe 2005, WHO 2015). Health and social care staff have an important role in facilitating a healthy situational transition. If interventions are to be effective, it is important to understand what factors facilitate and/or hinder the transition process.

The relocation of older people to long-term care facilities has been the subject of some narrative reviews, the most recent being Brownie et al (2014), Sury et al (2013), and Lee et al (2002). Lee et al (2002) and Brownie et al (2014) explored the perspective of older people and Sury et al (2013), in addition to older people, included family members. Lee et al's (2002) review examined older people's views and experiences following relocation to residential care; the number of articles included was not reported. Key findings reported were insight about older people's coping strategies, which included passive acceptance, making the best of available choices, and reframing.

Brownie et al's (2014) systematic literature review of 19 articles aimed to identify factors that impact on residents' transition and psychological adjustment to long-term care

facilities. The review was informed by the concept of home and Bridges' (2004) transition model for leading and managing organisational transition. Adjustment was reported to be influenced positively by factors such as older people being able to retain personal possessions, continue valued social relationships, and establish new relationships within the care facility. Sociocultural values and ethnic background were predictors of adjustment. Brownie et al excluded studies that had included older people with cognitive impairment. We know that the health profiles of older people in care homes are complex; currently the prevalence of dementia for older adults in UK care homes is estimated at 69% (62.7% for males and 71.2% for females, aged 60 years to 90+ years) (Prince et al 2014), and one in three people over 65 years in the UK will die with a form of dementia (Age UK 2017 (b)). Understanding the relocation needs of all older people is therefore crucial. Sury et al (2013) reviewed 49 studies to understand the adjustment of people living with dementia relocating to a nursing home and their families. They reported that adjustment was influenced both positively and negatively by factors that included: the involvement of the older person in decision making about the relocation, orientation and induction to the care facility pre- and post- relocation, and a person-centred approach to care. None of these reviews used systematic methods for data synthesis and only Brownie et al (2014) reported on study quality.

Most recent is Sullivan and Williams' (2017) qualitative meta-synthesis of older adults' transition experiences to long-term care facilities, guided by Meleis's Theory of Transition. Eight studies were reviewed and three themes were identified: loss requiring mourning; stability sought by gaining autonomy and; acceptance when inner balance is achieved (pg45). All participants had already relocated to the facility, however, only studies conducted in the USA or Canada between 2005 and 2015 were included.

We have not identified a published systematic review that examines transition conditions for older people who have relocated to a long-term care facility that has included older people, families and care facility staff. Our review aimed to address this gap; eliciting multiple perspectives will help achieve a fuller understanding of what might shape a healthy transition for older people. This is essential for an evidence-based approach to the development of interventions to prepare and support older people, families and care staff.

Aim

The SPICE framework (Booth 2006) was used to formulate the review question (See Supporting Material Table 1). This framework addresses 'Setting – where?', 'Perspective – for whom?', 'Intervention – what?', 'Comparison – compared with what?', and 'Evaluation – with what result?'. The aim of the review was to address the question: What factors facilitate and inhibit transition for older people who have relocated to a long-term care facility?

Methods

This review was conducted in accordance with the guidance of the Centre for Reviews and Dissemination for undertaking systematic reviews in healthcare (University of York 2008).

The search strategy was developed with the assistance of a Library Learning and Teaching Manager. Supporting Material Table 2 sets out the key search terms and synonyms. Searches were conducted by one researcher (VT) using five electronic databases: PsychINFO, British Nursing Index, CINAHL, MEDLINE and Web of Science. A supplementary search strategy was searching the reference lists of all included studies. The databases were searched for the period January 1990 to October 2017. Grey literature searches were conducted using Google Scholar, and Social Science Research Network (SSRN).

Qualitative, quantitative and mixed methods studies were included to maximise sources of evidence (Harden 2010). Inconsistency about the definition of old age, along with the lack of a universally agreed numerical criterion (Caldwell et al 2008) informed our decision to define older adults as ≥65 years (Golden et al 2009). A long-term care facility was defined as a facility that provides continuing care for older adults with a range of care needs and on a permanent residential basis, specifically nursing care homes (providing care which must be supervised by a registered nurse) and residential care homes (providing personal care that does not have to be supervised by a registered nurse) (See Supporting Material Table 3).

Study Screening and Selection

The searches identified 1,980 papers. Paper screening and selection was conducted using a two-stage process. For Stage 1 the titles and abstracts, where available, were screened independently by two researchers (JF and VT) using the inclusion and exclusion criteria. When it was not possible to decide using the title and abstract, the full text was obtained and read independently by JF and VT. Meetings were held to discuss independent screenings and to reach consensus. Stage 1 identified 68 papers. For Stage 2, the full-texts of the 68 papers were retrieved and screened using the inclusion and exclusion criteria. The results of Stage 2 screening were discussed with any discrepancies resolved by consensus resulting in 34 items. The reference lists of all included papers were also scanned, no additional papers were identified. Stage 2 screening resulted in a final sample of 34 papers (Figure 1 PRISMA Flow Diagram).

Insert Figure 1 here

Quality Appraisal

Quality appraisal was conducted independently by JF and VT. Qualitative studies were appraised using the CASP (2013) qualitative checklist comprising 10 items relating to rigour, credibility and relevance of qualitative studies. The quantitative studies (6 items) and mixed methods studies (13 items) were appraised using the MMAT quality appraisal tool (Pluye et al 2011). All items were scored as 'yes', 'no', 'can't tell'. Any differences between JF and VT were resolved by discussion. Studies were scored as 'high', 'medium' or 'low' quality. No study was excluded due to research quality as we aimed to describe and integrate all published research on this topic (Table 1).

Insert Table 1 here

Data Extraction

The study data extracted were: study title, author, publication year, country, aim, design, setting and sampling, method(s) of data collection, and data analysis strategy. Study findings were extracted from the findings/results section of each paper. Study findings were extracted independently by two researchers (JF, BK) and reviewed by a third (VT) to ensure accuracy and completeness.

Data Synthesis

Thematic synthesis was conducted using a three-stage process (Thomas & Harden 2008). Stage 1: all qualitative findings from the different stakeholders were coded inductively line by line by one researcher (JF). Throughout this process data about key characteristics of

each study and original data were re-read as necessary to ensure coding was true to the original data. The preliminary coding framework was reviewed and discussed with VT to ensure accuracy and consistency of interpretation and adequacy of the developing coding framework; VT scrutinised in depth the coding for 7 of the 27 studies. Stage 2: review of the coding with grouping to generate descriptive themes and subthemes. We drew upon Meleis's Transitions framework (Meleis 2010) for data synthesis, specifically, the domain 'transition conditions' to classify potential facilitators and inhibitors as personal, community or societal. One researcher undertook synthesis (JF). A second researcher (VT) provided written feedback on the draft synthesis with discussion resulting in the development of a final agreed version. Synthesis of the quantitative studies and quantitative components of the mixed methods studies was conducted by one researcher (VT) and a similar process was used for writing and reviewing the draft findings and agreeing a final version. The synthesised qualitative and quantitative findings were brought together to identify themes and facilitators and inhibitors to answer the review question. The Stage 3 analytical themes were informed using a map of the descriptive themes and exploring relationships between these.

Results

The searches produced 1,980 results. A process of screening of titles and abstracts resulted in 68 full text papers being read and 34 papers were selected that met the inclusion criteria; 25 qualitative studies, 7 quantitative studies and 2 mixed methods studies (See Supporting Material Table 4).

Description of the Studies Included

Eleven studies were conducted in the USA, 5 in the UK, 5 in Sweden, Switzerland and Norway, with the remainder conducted in Canada (4), China (3), Ireland (2), Taiwan (1), South Korea (1), Australia (1) and France (1). Sixteen of the 34 studies aimed to describe the needs and experiences of older people following relocation to a long-term care facility, others investigated adjustment (seven) or adaptation (six), family contribution to transition following relocation (four), and the concept of home following relocation (two). Six studies were informed by theoretical or conceptual frameworks, namely self-determination theory (O'Connor & Vallerand 1994, Altintas et al 2017), social learning theory (Johnson et al 1998), Meleis's transitions theory (Koppitz et al 2017), adaptation (Hersch et al 2003), and space and place (Falk et al 2012). For the qualitative studies, there was diversity of approaches, methods of data collection and data analysis. All the quantitative studies used a cross-sectional questionnaire survey, and the mixed methods studies used a cross-sectional questionnaire survey with individual interviews or focus groups. The methodological quality of the included studies was variable, 20 rated as high, 12 as medium and 2 as low (Table 1).

Participant Characteristics

The participant samples differed across the studies: 26 of the 34 studies included older people, six studies explored the staff perspective (Reed & Payton 1997, Reed & Morgan 1999, Wiersma 2010, Eika et al 2014, Ellis & Rawson 2015, Gilmore-Bykovskyi et al 2017), and five studies investigated family members' perspectives (Reed & Morgan 1999, Davies & Nolan 2006, Wu et al 2009, Sandberg et al 2012, O'Shea et al 2014). Relocation of older people to long-term care facilities was both planned and unplanned, and key reasons, when reported, included a decline in physical and mental health, and the older person no longer being able to live at home with or without support services. In 25 studies cognitive status was used as a screening criterion for older people participants, several reported using a minimum score on a test such as the Mini Mental State Examination (e.g. Iwasiw et al 1996, Brandburg et al 2012, Johnson & Bibbo 2014, Altintas et al 2017), and for others it was defined as having capacity to give informed consent (e.g. Reed & Payton 1997, Lee et al 2013).

Findings

Personal and community focused facilitators and inhibitors were identified that mapped to four themes: resilience of the older person, interpersonal connections and relationships, this is my new home, and the care facility as an organisation (Table 2). Some facilitators and inhibitors were not exclusive to one theme, for example, continuity of older people's values, beliefs and personal identity, and factors related to organisational culture.

Insert Table 2 here

Resilience of the older person

Resilience of the older person to make sense of and come to terms with their relocation and the associated gains and losses was a theme. Within this theme several potential facilitators and inhibitors were identified that corresponded with Meleis's personal and community transition conditions. For older people, perceived gains included: viewing the relocation as their best option (e.g. because they were no longer able to live at home due to deteriorating health, needing assistance with daily living, and not wanting to burden adult children); and, acknowledging and accepting that whilst the care facility was not their home, there were benefits to living there such as being safe, having shelter and respite, having their needs taken care of 24/7, and no longer having to worry (Kahn 1999, Lee 1999, Reed & Morgan 1999, Hersch et al 2003, Kydd 2005, Brandburg et al 2012, Johnson & Bibbo 2014, Ellis & Rawson 2015, Koppitz et al 2017).

Self-efficacy was a predictor of overall adjustment to relocation (Johnson et al 1998- R2 .35 $p<0.00$; Lee 2010- $\beta=0.131$ $p<0.05$). Lee (2010) found that positive preconceptions predicted successful overall adjustment ($\beta=0.135$, $p<0.05$). Similarly, self-determined motivation was reported to have a positive effect on adjustment (O'Connor & Vallerand, 1994, Curtiss et al, 2007). Making sense of and coming to terms with their new situation seemed to be facilitated by personal attributes such as being patient, flexible, co-operative, and positive (Wilson 1997, Kahn 1999, Hersch et al 2003, Brandburg et al 2012, Falk et al 2012). A potential facilitator was older people having a personal philosophy to draw upon to help make sense of their lives, to give meaning to their new situation, and to facilitate tolerance and acceptance (Iwasiw et al 1996, Hersch et al 2003). For some older people this was expressed as accepting their fate (Wu et al 2009), living for today rather than dwelling on the past or worrying about tomorrow, having a 'survivor mentality' (Brandburg et al 2012),

having an inner strength to overcome the challenge of relocation as they had done for other life challenges (Lee et al 2013), and recognising that they had a personal responsibility to make the best of their new situation (Kahn 1999, Johnson & Bibbo 2014).

For some, being able to continue their faith facilitated a sense of purpose (Hersch et al 2003), and continuity of their values, beliefs and personal identity. Sasson (2001b) found that religiosity was significantly correlated with relocation adjustment (r=.212 p=0.043) and satisfaction (r=.239 p=0.022), although after controlling for other characteristics (ethnic background, demographics, functioning and social support), these associations were reduced. In a related study Sasson (2001a) found that ethnic behaviour (i.e. involvement in social groups, cultural practice, food, music and customs of one's ethnic group) was significantly associated with adjustment (r=.22, p=0.035) and satisfaction (r=.24, p=0.023).

Potentially facilitating transition was older people using strategies such as reframing (Porter & Clinton 1992), talking about their losses and seeking solutions (Brandburg et al 2012), and using a small steps approach (e.g. beginning with essential tasks such as learning to eat and sleep in their new living place (Johnson & Bibbo 2014). Other strategies were learning the rules, regulations and routines of the care facility (and the consequences of non-compliance) to help 'fit in' and to have one's needs met (Iwasiw et al 1996, Lee et al 2002, Brandburg et al 2012, Sussman & Dupuis 2014), and adopting the culture of their new environment (Lee 1999). This learning was facilitated by observing co-residents to understand how they behaved and spent their days, talking with co-residents, and having a resident role model/mentor (Reed & Payton 1997, Lee, 1999, Lee et al 2002).

Potential inhibitors were viewing relocation as being about losses, powerlessness and discontinuity (Kahn 1999, Lee 1999, Reed & Morgan 1999, Kydd 2005, Wiersma 2010, Brandburg et al 2012, Ellis & Rawson 2015, Koppitz et al 2017). Losses were commonly related

to health and well-being (e.g. health problems, frailty, vulnerability, social dependency), home and possessions, roles and relationships (e.g. as a spouse/partner, parent, grandparent), past lives, daily routines and hobbies, privacy, independence, and identity. A potential inhibitor was having an attitude that living in the care facility was something they had to do (Porter & Clinton 1992, Wilson, 1997, Fraher & Coffey 2011). There was a sense of 'making do', a passive or resigned acceptance of 'life now', which they felt unable to change (Lee et al 2013, p52). For some older people reframing did not occur. They were reported as having no choice, being stuck and angry in their living situation, waiting for death, and having given up (Johnson & Bibbo 2014, Falk et al 2011, Falk et al 2012).

Interpersonal connections and relationships

The theme interpersonal connections and relationships for older people centred on co-residents, care facility staff, and family and significant others beyond the care facility. Potential facilitators and inhibitors corresponded with Meleis's personal and community transition conditions.

Whilst recognising that some older people prefer their own company (Reed & Payton 1997, Lee 1999, Lee et al 2002), establishing new connections and relationships with co-residents was a facilitator that provided social and practical support, friendship, and enhanced continuity of self (Wilson 1997, Hersch et al 2003, Falk et al 2012, Lee et al 2013, Johnson & Bibbo 2014). Lee (2010) found that greater perceived emotional support from co-residents ($\beta=0.342$ $p<0.001$) and staff ($\beta=0.220$ $p<0.01$) predicted better adjustment to relocation. New connections and relationships seemed to be facilitated by older people having a positive attitude to get along with others (Lee et al 2002, Brandburg et al 2012, Falk et al 2012), joining buddy groups, and taking on advocate and mentor roles to support co-

residents (Hersch et al 2003). Establishing new connections and relationships with co-residents also seemed to be facilitated by factors such as: involvement in the decision to move into the care facility (Iwasiw et al 1996); introductions to co-residents by resident mentors (Reed & Payton 1997); family members actively encouraging and facilitating new social networks in the care facility (Sandberg et al 2002, Davies & Nolan 2006); and older people engaging with meaningful activities and events such as exercise, music, games, and religious activities and services (Iwasiw et al 1996, Hersch et al 2003, Brandburg et al 2012, Falk et al 2012, Sussman & Dupuis 2014, Ellis & Rawson 2015). New social networks with co-residents were consolidated by reciprocity, with residents helping each other (Reed & Payton 1997). The geography, design and significance of shared spaces within the care facility was identified as a potential facilitator or inhibitor, conducive to connecting with co-residents and staff (Falk et al 2012) or creating feelings of abandonment (Falk et al 2011).

For some older people interpersonal connections and relationships with co-residents were not described positively and were a potential inhibitor for a healthy transition. Negative experiences were reported as being intrusive, not allowing for privacy, and causing offense, for example, uninvited or unwelcomed interactions and co-residents' lack of insight about social norms and communal living etiquette (Reed & Payton 1997, Wilson 1997, Johnson & Bibbo 2014). Some older people were cautious about forming connections or relationships with co-residents which was influenced by them not knowing or not having been introduced to each other. Being opposed to the relocation also seemed to inhibit relationship-building with co-residents. Iwasiw et al (1996) reported that older people opposed to relocation initiated little interaction, were emotionally distant, focused on self, and displayed feelings of anger, depression and shock. Older people being ageist and having negative views about older people with physical and/or mental health impairments was also an inhibiting factor

(Lee et al 2013). Other potential inhibitors were staff positioning residents to sit beside co-residents whom they did not know or like (Reed & Payton 1997, Lee et al 2013), and a lack of staff attention to facilitating introductions, connections, and friendships between residents (Reed & Payton 1997, Davies & Nolan 2006). Activities were a way to forge connections and relationships with co-residents, however, potential inhibitors were care facilities not offering activities, activities not meeting the approval of residents, residents not knowing about them (Lee 1999, Lee et al 2013) or not being able to participate due to health limitations (Koppitz et al 2017). Altintas et al (2017) found that feeling connected and secure in relationships and part of the care facility community enhanced residents' leisure practice, self-determined motivation, and adaptation. Similarly, Johnson et al (1998) found that residents with stronger self-efficacy reported more positive affect and were more involved in scheduled activities.

Interpersonal connections and relationships between older people and care facility staff was identified as a potential facilitator and inhibitor for a healthy transition (Iwasiw et al 1996, Reed & Payton 1997, Davies & Nolan 2006, Lee 2010, Brandburg et al 2012, Falk et al 2012, Sandberg et al 2012, Eika et al 2014, Johnson & Bibbo 2014, Sussman & Dupuis 2014). The nature of the older person-staff relationship was described in various ways, for example, as supportive, like a family (Hersch et al 2003, Brandburg et al 2012), as being acquainted (Falk et al 2012), and as distant and superficial (Lee 1999). Facilitating meaningful older person-staff relationships was staff knowing or making an effort to get to know residents and their families (Eika et al 2014). Inhibiting factors were uncaring conversations by staff, where older people felt talked down to (Lee 1999), and feeling that they had to be co-operative with staff (Lee et al 2002), as well as organisational factors such as staff workload and time constraints which impacted negatively on opportunities for staff to connect meaningfully with residents (Reed & Payton 1997).

Continuing valued relationships with family and significant others beyond the care facility appeared to be important in facilitating older people's transition (Iwasiw et al 1996, Sandberg et al 2002, Hersch et al 2003, Wu et al 2009, Lee 2010, Zhan et al 2011, Brandburg et al 2012, Falk et al 2012, Ellis & Rawson 2015, Koppitz et al 2017). This included being able to see these people in person, and/or keeping connected via communication media such as letters and technology supported conversations (Hersch et al 2003, Falk et al 2012, Koppitz et al 2017). These relationships helped to maintain older people's self-identity, supported them in their day-to-day living, helped to bridge the past and the present, provided an important link to the outside world, and provided social, emotional, practical and financial support. Lee (2010) found that older people who were satisfied with family relationships adjusted better to their relocation ($\beta=0.202$, $p<0.01$). Another potential facilitator was families adopting new roles post relocation of the older person (Sandberg et al 2002, Davies & Nolan 2006, O'Shea et al 2014), which included: using their knowledge of the older person to enhance the quality of the care experience (e.g. by making staff aware of the older person's unique identity including their likes and dislikes); working to enhance and enrich older persons' lives in the care facility by encouraging them to continue with favoured routines and past-times, as well as new opportunities; facilitating communication between the older person and care facility staff; and keeping an eye on care delivery in an effort to ensure best care. Other facilitators were family continuing to nurture a good parent-child relationship, and helping to maintain connections and relationships with the wider family and others beyond the care facility (Sandberg et al 2002, Davies & Nolan, 2006). Potential inhibitors were the influence of cultural beliefs/norms with the older person distancing themselves from their families to 're-establish their lives' (Lee 2002 p671), disharmony with family members (Lee et al 2002, Hersch et al 2003), loss of self-identity (e.g. no longer being seen as part of a couple by adult

children (Sandberg et al 2002), and being physically displaced from one's partner/spouse (Sandberg et al 2002, Wiersma 2010).

This is my new home

The care facility as a new home for residents was identified as a theme and potential facilitators and inhibitors corresponded with Meleis's personal and community transition conditions. Home was a quality within the care facility, a home-like place to live, but not replacing one's home, and was experienced in different ways by older people. For some older people the care facility was their 'home now' (Kahn 1999), a place to sleep and eat (Falk et al 2012), and almost like home, but without their families (Lee et al 2002). For others is was regarded as a place to die (Falk et al 2011, Johnson & Bibbo 2014), not as home (Kahn 1999, Fraher & Coffey 2011), and as a temporary arrangement (Falk et al 2012, Lee et al 2013). A potential facilitator was older people being enabled to create their own space, to have a place they could call their own (Iwasiw et al 1996, Kahn 1999, Falk et al 2012, Johnson & Bibbo 2014, Sussman & Dupuis 2014). This included the involvement of older people in deciding what personal belongings should be brought from their former residence and arranging these in their new space (Kahn 1999, Johnson & Bibbo 2014, Sussman & Dupuis 2014). Being able to bring and arrange personal possessions had the potential to make their private space useful, comfortable and true to their self-identity (Sussman & Dupuis 2014, Koppitz et al 2017). Within this private space, older people had choice and control and could exercise self-determination about what they did (Brandburg et al 2012), who they 'invited in' and 'kept out' (Falk et al 2012), and were able to transport themselves mentally to their former home (Kahn 1999). For some older people the physical setting or personal belongings were not

important, instead it was about continuity of their values, beliefs and personal identity (Hersch et al 2003).

Factors that inhibited older people creating their own space were not having the opportunity to choose what personal possessions to bring to the care facility (Johnson & Bibbo 2014), having to limit their choice of personal possessions due to having to downsize (Wilson 1997, Wiersma 2010, Ellis & Rawson 2015, Koppitz et al 2017), or because of a temporary room allocation (Iwasiw et al 1996). Other inhibitors were staff values and practices, and care facility regulations and processes regarding safety and risk (Iwasiw et al 1996, Wiersma 2010, Johnson & Bibbo 2014, Sussman & Dupuis 2014, Koppitz et al 2017).

Related to creating a personalised space, was privacy for self and co-residents. For some older people the ideal was having their own bedroom with/without private bathroom facilities (Iwasiw et al 1996, Wilson 1997, Kahn 1999, Curtiss et al 2007, Fraher & Coffey 2011). Respect for privacy and personal space was shown by staff and co-residents in different ways, for example, by staff knocking prior to entering residents' rooms, and older people being supported to go to their own room when they chose (Sussman & Dupuis 2014), and respect of personal property by co-residents. Inhibitors included noisy and wandering co-residents (Ellis & Rawson 2015); staff disregard for privacy by entering a resident's room unannounced (Sussman & Dupuis 2014); a lack of privacy at mealtimes for those needing full assistance; and for those sharing a bedroom, a lack of privacy to receive one's visitors and at critical times such as when a co-resident was ill or dying (Lee 1999, Fraher & Coffey 2011). For Chinese older people (Lee 1999, Lee et al 2002) a facilitator was living close to co-residents and others, reflecting the Chinese cultural values of tolerance, acceptance, and gratitude. For these older people there was an understanding that communal living was about meeting the collective needs of the community rather than individual needs. The internal and external design of the

care facility was also a potential facilitator for creating a new home, enabling older people to pursue hobbies and interests and to have a sense of calm and peace (Fraher & Coffey 2011, Ellis & Rawson 2015).

The care facility as an organisation

The theme of the care facility as an organisation centred on moving in, organisational culture, approaches to care, and workforce factors. Facilitators and inhibitors corresponded with Meleis's personal and community transition conditions.

A facilitator and also an inhibitor was management of 'moving in'. Facilitating factors were older people feeling that their arrival was expected, having designated staff to manage the admission process who were confident and experienced, and leadership that communicated to all staff the significance of moving in for older people and their families (Eika et al 2014, Sussman & Dupuis 2014). Other facilitators were older people and their family members being welcomed at the time of admission, orientation processes that included being introduced to staff and co-residents, and being made to feel valued (Eika et al 2014, Sussman & Dupuis 2014, Ellis & Rawson 2015). Potential inhibitors were the care facility not being able to influence arrival time so that an older person arrived at a particularly busy time, staff adopting a business as usual approach to the older person's moving in, and admission being manged as a process of paperwork and tasks and less about the older person (Wiersma 2010, Eika et al 2014).

Approaches to care had the potential to inhibit transition. This included: care approaches that promoted resident dependence rather than self-management, with staff not valuing a philosophy of self-care and not spending time to encourage self-care (Eika et al 2014), a task focused approach (Wiersma 2010) that did not consider individual preferences

and the uniqueness of residents (Sandberg et al 2012), and the organisation of care (e.g. ad-hoc approaches for staff to gain and share knowledge about residents, handover reports that were too short, and staff not valuing regular updated written information about residents) (Eika et al 2014). A potential inhibitor was care facility rules, regulations and routines (Iwasiw et al 1996, Eika et al 2014, Sussman & Dupuis 2014, Koppitz et al 2017). This included an over-emphasis on safety and risk minimisation (Eika et al 2014), older people being expected to conform to staff expectations, and a greater focus on organisational rather than individual resident needs (e.g. for getting up time, having to have meals in the dining room, and prescribed care routines). Wiersma's (2010) study reported that older people were "compliant and submissive" regarding rules, regulations, and behaviour expectations, and that consequences of not conforming included older people being labelled negatively, having to wait unnecessarily for staff assistance, and the use of sedating medication. Rules, regulations, and behaviour expectations overwhelmed older people's efforts to create their own personal space, undermined their abilities, and interfered with their preferences and routines within and beyond the care facility (Iwasiw et al 1996, Sussman & Dupuis 2014, Koppitz et al 2017). Older people responded to rules, regulations and routines of the care facility in various ways which included embracing them (Lee 1999), resenting them (Iwasiw et al 1996, Wilson 1997, Johnson & Bibbo 2014), and learning to navigate them by re-patterning their lifestyles and daily routines (Lee 2002, Sussman & Dupuis 2014, Koppitz et al 2017).

A potentially inhibiting factor was inadequate staffing levels which contributed to care delivery being hurried, delays in staff responding to residents' calls for assistance (Wiersma 2010, Lee et al 2013), 'doing for' residents rather than encouraging independence, and a lack of time for staff to talk with residents (Ellis & Rawson 2015).

Facilitating factors were older people being satisfied with the care facility and with the care that they received (Wu et al 2009, Lee 2010, Lee et al 2013). Lee (2010) found that greater satisfaction with the care facility was associated with greater adjustment (β=0.212 $p<0.01$) and resident satisfaction with care was significantly correlated with adjustment ($r=.27$, $p=0.012$). Staff in Gilmore-Bykovskyi et al (2017) reported that knowing and understanding the older person was a marker of high quality care and necessary for person centred care.

Discussion

The desired outcome for older people who have relocated to a long-term care facility is a healthy transition, that is, a place of living that is caring and where the older person's fundamental physical, safety, and love and belongingness needs can be met through to the end of life. Our systematic review identified factors that may facilitate and or inhibit a healthy transition for older people who have relocated to a long-term care facility, with implications for research, service and practice development. Facilitating and inhibiting factors were personal and community focused and mapped to four themes: resilience of the older person, interpersonal connections and relationships, this is my new home, and the care facility as an organisation. These themes resonate with the wider international literature on older people living well in long-term care facilities, for example, Nolan et al's (2006) Senses Framework, where older people, families and staff identified the need for a sense of security, continuity, belonging, purpose, fulfilment and significance, and also the national My Home Life initiative (http://myhomelife.org.uk/) with its vision of best practice, relationship centred care, caring conversations, and being appreciative.

For the theme resilience of the older person, person focused transition facilitators included self-efficacy, self-determined motivation, continuation of one's faith, values and beliefs, ethnic identity, a positive personal philosophy, and personal coping strategies. These findings concur with other sources which have highlighted the need for autonomy if older people are to create and sustain a new sense of self following their relocation to a long-term care facility (Sullivan and Williams 2017). Conversely, an inhibitor was viewing relocation and life in a long-term care facility negatively. These facilitators and inhibitors have the potential to inform the development of an intervention that targets resilience, to promote older people's psychological, social, and physical well-being. Intervention development requires consideration of the potential contribution of theories such as Meleis's transitions theory, and self-determination theory, as well as conceptual models such as adaptation and adjustment.

The second theme was connections and relationships with co-residents, staff, and families which had the potential to facilitate and inhibit transition. Bradshaw et al (2012) similarly reported that meaningful relationships with co-residents and staff are important for a good care home life, as are relationships between residents, staff and families (Davies 2005, Ryan & McKenna 2015). Continuing valued relationships and beginning new relationships was identified by Brownie et al (2014) as a factor that facilitated adjustment for older people and our findings corroborate this but from the perspective also of staff and families. Earlier, Brown Wilson (2009) studied relationships between care home residents, staff and families and key influencing factors were the design of the care home, leadership, continuity of staff, the personal philosophy of staff, and the contribution of residents and families. Our findings identify several person and community focused transition facilitators and inhibitors that can inform the development of an intervention that addresses the area

of connections and relationships between residents, families and staff following older people's relocation to a long-term care facility. One component of an intervention should be an evidence based staff training programme to advance understanding and enhancement of transition post relocation that addresses enabling choice, independence and self-identity for the older person. Key to the success of any transition intervention is the involvement of care facility staff, residents and families in co-design and implementation, appreciation of the contextual factors of individual care facilities, and the identification of meaningful process and outcome measures. It is noteworthy that of the 34 studies included in this review only five investigated the perspective of family members and only six investigated the staff perspective which supports our call for the involvement of all key stakeholders.

The third theme was this is my new home and transition facilitators included older people being enabled to create their own space, retain cherished personal possessions, express their self-identity, have choice and privacy. This concurs with the findings of Davies and Brown Wilson (2007) who argued that care facilities should focus on creating a sense of community. Similarly, for older people in Gott et al (2004) home was more than a physical place, it was "symbolic of familiarity, autonomy and above all the presence and memories of loved ones." (pg. 465). The design of the physical environment was a facilitator and inhibitor for this theme and also for the theme 'connections and relationships' and requires further investigation to understand more fully what is a therapeutic environment (Day et al 2000) for long-term care facilities and how this might enhance a healthy transition for older people. This should also consider how to address factors such as culturally competent care and meeting the needs of older people from minority ethnic groups (Mold et al 2005), and older people with particular health needs such as dementia.

The fourth theme was the care facility as an organisation. Facilitating transition was older adults being satisfied with the care facility and the standard of care. As of July 2016, of the 9,100 residential care homes in England registered with the Care Quality Commission whilst 1% were rated as outstanding and nearly three quarters were good (73%), over a quarter required improvement (24%) or were inadequate (2%). For the 3,649 nursing homes, 1% were outstanding and 58% good, whilst two fifths required improvement (37%) or were inadequate (4%) (CQC, 2016). These figures suggest that whilst there is much good provision, many long-term care facilities need to improve.

Potential transition inhibitors included moving in processes and practices; care approaches that promoted dependence, were task focused, and did not promote resident centred care; an over-emphasis on risk minimisation; and organisational constraints such as inadequate staffing levels. Long-term care facilities require staff with knowledge, skills and values to meet the needs of older people, who can deliver excellent care, and who are committed to helping create an enriched care environment. The influence of organisational culture on the quality of care is known (Van Beek & Gerritsen 2010, Killett et al 2013, Dixon-Woods et al 2014) as is the impact of how staff are organised, managed and supported on resident outcomes (Flynn et al 2010, Choi et al 2011, Spilsbury et al 2015). We need to know more about how organisational culture influences transition following relocation and the impact for residents' psychosocial wellbeing (e.g. mood, life satisfaction, feeling connected, confidence and coping) and physical well-being (e.g. mobility, mastery of new skills).

Limitations and Strengths of the Review

This systematic review has contributed to the field by examining multiple perspectives; gaining insights from staff and families in addition to older people. Studies not reported in

peer reviewed journals and not reported in English were excluded which is a potential publication and language bias. Our searching and screening processes were rigorous to maximise identifying relevant studies and we have drawn upon non-empirical literature to inform our wider thinking and discussion of the topic. Meleis's theory of transition framed our conceptualisation of situational transition and we used the transition conditions domain to help classify facilitators and inhibitors. Our review highlighted the heterogeneity of research that has investigated older people's transition following their relocation to a long-term care facility. The studies used a multiplicity of terms and concepts such as experiences, adaptation, adjustment, relocation, and home, few were theoretically framed, and they were of varied methodological quality. Timelines for investigation of the transition process varied, for some studies data were collected from day one following relocation, for other studies older people had been resident for months or years. These shortcomings limit generalisability of the findings and highlight the need for further research in some areas to generate a fuller and robust understanding of factors that facilitate and inhibit the transition of older people post relocation.

Conclusions

This systematic review identified potential transition facilitators and inhibitors for older people who have relocated to a long-term care facility on a permanent basis. These findings have the potential to inform the development of interventions to target the key areas of resilience of the older person, interpersonal connections and relationships, the care facility as a home, and the care facility as an organisation.

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Figure 1 PRISMA Flow Diagram

Figure 1 PRISMA Flow Diagram

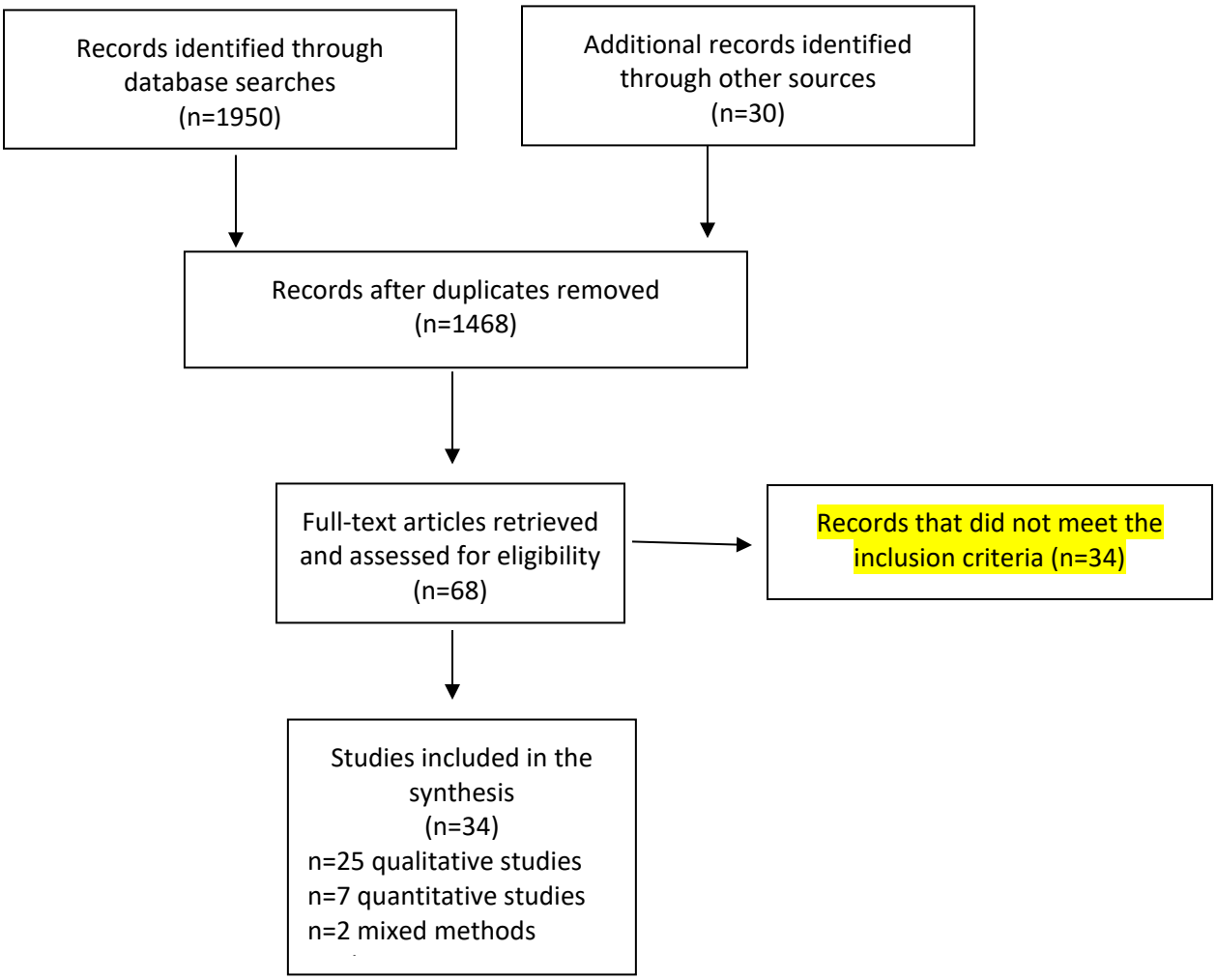

Table 1 Summary of Included Studies

Author, publication year, country	Population & setting	Aim(s)	Design, methods of data collection, data analysis procedures	Sampling strategy & sample characteristics	Quality Appraisal Indicator- 'H'=High, 'M'=Medium, 'L'=Low
Porter & Clinton, 1992, USA	Older people. 54 nursing homes.	- To explore how older adults experience changes associated with living in a nursing home.	- Phenomenological approach. - Individual interviews. - Giorgi's phenomenological method of data analysis.	- Random sampling weighted by age, setting and length of stay. - n=243. - Age range 65-75 years. - Males n=61, Females n=182. - Length of stay ≥ 6 months.	M
O'Connor & Vallerand, 1994, Canada	Older people. 11 intermediate care nursing homes.	- To examine the relationships between motivation, the degree of self-determination provided by nursing homes, and general psychological adjustment.	- Questionnaire survey using Elderly Motivation Scale, Satisfaction with Life Scale, Self-Esteem Scale, the Beck Depression Inventory, 4 questions about meaning in life, physical health, medication regimen, and assessment of the environment. - Framed using Self-Determination Theory.	- Random sampling of care homes and older people. - n=111. - Mean age 80.5 years. - Males n=18, Females n=93. - Mean length of stay 3.8 years.	H
Iwasiw et al, 1996, Canada	Older people. 5 long term care facilities (LTCF).	- What are the experiences of newly admitted residents in the first 2 weeks in a LTCF following relocation from home? - What are the needs, priorities and expectations of residents during the 1st 2 weeks in a LTCF? - What are the residents' views about how this relocation can be facilitated?	- Qualitative study. - Individual interviews. - Constant comparative method of data analysis.	- Purposive sampling. - n=12. - Age range 67-96 years. - Male n=2, Females n=10. - Length of stay ≤ 2 weeks.	H

Reed & Payton, 1997, UK	Older people. Staff members. 6 care homes- nursing & residential, one local authority in England.	- To examine the processes of adaptation that older people engage in when moving into care homes.	- Qualitative. - Individual interviews with older people. - Focus groups with staff. - Thematic analysis.	- Sampling approach not reported. - n=40 older adults. - Sample size for staff not reported- 10 focus groups with 3-6 participants. - Interview with older adults pre-move, then 3 months post move, with last interview by month 6.	M
Wilson, 1997, USA	Older people. 3 religious affiliated LTCFs.	- What are the initial experiences of older adults in nursing home life when the admission was planned or unplanned?	- Grounded theory. - Individual interviews. - Field notes of interviews and observations. - Constant comparative method of data analysis.	- Sampling approach not reported. - n=15. - Age range 76-97 years. - Males n=4, Females n=11. - Length of stay not reported. - Interviews on alternate days from the day of admission for 2 weeks and again one month post admission.	M
Johnson et al, 1998, USA	Older people. 2 rural nursing homes.	- To investigate factors which may predict successful nursing home adjustment. - To evaluate the different types of measures for locus of control (general and specific) and self-efficacy (general, specific, and barrier) to determine their comparative ability to predict successful nursing home adjustment.	- Cross sectional questionnaire survey using: Specific Self-efficacy (SE) Scale, SE Scale, Barrier SE Scale, Desired Control Measure, Abbreviated Rotter Scale, Demographic questionnaire, Profile Mood States, Depression/Dejection Scale, Activity level during a 1 month period. - Framed using Social Learning Theory.	- Sampling approach not reported. - n=58. - Average age 81.9 years. - Males n=15, Females n=43. - Average length of stay 2 years.	H
Kahn et al, 1999, USA	Older people. 1 Jewish nursing home- 145 beds.	- To describe the process older adults successfully used to adapt to the dual nature of the nursing home environment.	- Ethnography. - Individual interviews, participant observations. - Interpretative analysis.	- Convenience sampling. - n=21. - Age range 66-93 years. - Males n=2, Females n=19. - Mean length of stay 2.5 years, range 3 months to 10 years.	H
Lee, 1999, China	Older people. 1 residential care home- 126 beds.	- To explore the experiences of transition into residential care among elderly Chinese people in Hong Kong.	- Qualitative. - Individual interviews. - Content analysis.	- Purposive sampling. - n=10. - Age range 68-88 years, mean 78 years. - Males n=6, Females n=4. - Length of stay not reported. - Interviewed one week after admission to care home.	M

Reed & Morgan 1999, UK	Older people. Family members. Staff members. 1 care home, 1 acute care/rehabilitation ward.	- To investigate a) the experience of older people making a move into a care home, and b) the observations of those that care for them, in order to identify indicators for practice development.	- Qualitative. - Individual interviews with family members and older adults. - Focus groups with staff members. - Method of data analysis not reported.	- Purposive sampling. - n=20 older adults, interviewed within 4 weeks of admission. - n=17 family members. - n=23 staff in focus groups.	M
Sasson, 2001a, USA	Older people. 1 long term care facility- 816 beds.	- To assess differences both within and between the Jewish and African American elderly with regard to effects of ethnic identity on their adjustment and satisfaction with nursing home living.	- Questionnaire survey using the Multigroup Ethnic Identity Measure (MEIM), the Nursing Home Resident Questionnaire (NHRQ), and the Adjustment Measure.	- Convenience sampling. - n=92 older adults (n=21 African-Americans and n=71 Jewish) - Mean age 86.6 years. - Males n=21, Females n=71. - Mean length of stay in days: - African-American residents (M = 841.5, SD = 614.3), Jewish residents (M = 1012.5, SD = 1168.4). - At time of participation had been resident in care facility for a minimum of 2 months.	H
Sasson, 2001b, USA	Older people. 1 long term care facility- 816 beds.	- To examine the association between religiosity, adjustment and satisfaction of nursing home residents in one long term care facility.	- Questionnaire survey using the Multigroup Ethnic Identity Measure (MEIM), the Nursing Home Resident Questionnaire (NHRQ), the Adjustment Measure.	- Convenience sampling. - n=92 (n=21 African-Americans and n=71 Jewish). - Mean age 86.6 years. - Males n=21, Females n=71. - Mean length of stay in days: African-American residents (M = 841.5, SD = 614.3), Jewish residents (M = 1012.5, SD = 1168.4). - At time of participation had been resident in care facility for a minimum of 2 months.	M

Lee et al, 2002, China	Older people. 1 nursing home-126 beds.	- To describe the process whereby Hong Kong Chinese residents adjust following nursing home placement.	- Grounded theory. - Individual interviews. - Constant comparative analysis.	- Theoretical sampling. - n=18. - Age range 70-86 years, mean age 79.2 years. - Males n=9, Females n=9. - Length of stay not reported. - Interviewed 1 week after admission and then monthly until data saturation achieved- 98 interviews in total.	H
Sandberg et al 2002, Sweden	Family members of older people who had relocated to a care home.	- To understand the role of children in the placement process.	- Grounded theory. - Individual interviews. - Grounded theory method of analysis.	- Purposive sampling. - n=13 adult children- 2 sons, 11 daughters.	H
Hersch et al, 2003, USA	Older people. 1 participant in a nursing home, 2 participants in personal care homes.	- To identify how decisions were made to change living arrangements of elders. - To describe the process of adaptation to relocation as it evolved over time including adaptive challenges encountered and adaptive strategies used to address them. - To identify indicators of successful adaptation to relocation.	- Phenomenology. - Individual interviews & field notes. - Phenomenological method of data analysis. - Informed by the concept of adaptation.	- Sampling approach not reported. - n=3 out of 5 to LTCF. - Age 71-94 years. - Males n=2, Females n=3. - Length of stay not reported. - Retrospective account of older people's experiences.	M
Kydd, 2005, UK	Older people. n=8 in nursing homes, n=13 in hospital waiting for entry to a care home.	- To look at what life was like for 21 older people in institutional care, with the focus on moving from one institution to another in Scotland.	- Qualitative. - Individual interviews. - Method of data analysis not reported.	- Sampling approach not reported. - n=13 older adults in transition. - Age range 72-95 years. - All females. - Time spent on the ward: 2 weeks–2 years, with an average of 6 months. - n=8 older adults in nursing homes. - Age range 77-90 years. - All males. - Length of stay: 1 to 24 months.	L

Davies & Nolan, 2006, UK	Family members. Relatives of older adults who were moved in nursing homes.	- To describe a range of caregiving roles described by relatives who have helped an older person to move into a care home, and continued to support them in that setting.	- Constructivist methodology. - Individual interviews. - Constructivist method of data analysis.	- Convenience sampling. - n=48. - Age range 35-85 years. - Males n=21, Females n=27.	H
Curtiss et al 2007, USA	Older people. 1 nursing home.	- To explore the joint effects of motivational style, length of residence, and voluntariness of the decision to relocate as these factors relate to nursing home adjustment, and to investigate any possible gender differences in such relationships.	- Questionnaire survey using Mini-Mental State Exam, Elderly Motivation Scale, Activities of Daily Living Scale, Marlowe-Crowne Social Desirability Scale, Affect Balance Scale, Self Esteem Scale, Desired Control Measure.	- Sampling approach not reported. - n=75. - Mean age 79.08 years. - Males n= 25, Females n= 50. - Mean length of stay 14.55 months.	H
Wu et al, 2009, Taiwan	Older people. Family members. 3 nursing homes- 2 rural setting, 1 urban setting.	- To generate a substantive theory to understand the phenomenon of nursing home care for older people in Taiwan.	- Grounded theory. - Individual interviews and participant observation. - Constant comparative method of data analysis.	- Theoretical sampling. - n=40 older adults. - Age range 65-93 years, mean age 81.07 years. - Gender not reported. - Length of stay not reported. - n=20 family members. - Age range 31-80 years. - Males n= 7, Females n=13.	H
Lee, 2010, South Korea	Older people. 7 nursing homes.	- To identify predictors of nursing home life adjustment.	- Cross-sectional survey using General Self-Efficacy Scale, Activities of Daily Living (ADL) Scale, Self-rated health, Social Support Scale, Nursing Home Adjustment Scale, Facility characteristics, Affiliation (religious or non-religious), and perceived general satisfaction with the facility. - Multiple regression analysis.	- Convenience sampling. - n=156. - Mean age 79 years. - Males n=31, Females n=125. - Average length of stay 3 years, ranging from 1 to 124 months.	H

Wiersma, 2010, Canada	Staff members. 1 LTCF- approx. 100 beds.	- To examine staff's perceptions of a person's coming to live in a long-term care environment.	- Hermeneutic phenomenology. - Individual interviews. - Hermeneutic phenomenological approach to analysis.	- Snowball sampling. - n=15 (management-3, recreation including social work-4, nursing staff-8).	H
Falk et al, 2011, Sweden	Older people. 3 residential care homes.	- To examine the effects of relocation on the residents' quality of life, well-being, and perceived person-centeredness, as well as to describe their experiences in relation to the relocation.	- Pre-test post-test mixed-method design. - Person-Centered Climate Questionnaire, Quality of Life in Late-Stage Dementia Scale (QUALID), Patient Mood Assessment Scale (PMAS), General Behavior Assessment Scale (GBAS). - Qualitative interviews.	- Sampling approach not reported. - n=155. - Relocation group n= 74, Females n=57. - Reference group n=81, females n=63. - Mean age 86 years. - Length of stay not reported.	H
Fraher & Coffey, 2011, Ireland	Older people. No. of nursing homes not reported- public and private sector.	- To explore older people's experience of the decision to relocate to long-term care and their early experiences post-relocation.	- Hermeneutic phenomenology. - Individual interviews. - Collaizzi's phenomenological method of data analysis.	- Purposive sampling. - n=8. - Age range 78-86 years. - Males n=2, Females n=6. - At time of interview had been resident in nursing home for <3 months.	M
Zhan et al, 2011, China	Older people. Family members.	- To examine the role of the family in long-term institutional elder care.	- Mixed-methods. - Survey of 140 urban elder care institutions in Nanjing. - Qualitative focus groups with older people and family members.	- Theoretical sampling. - n=19 older adults. - Age range 70-90 years. - Males n=8, Females n=11. - Length of stay not reported. - n=15 family members. - Age range 50-70 years. - Males n= 4, Females n= 11.	M
Brandburg et al, 2012, USA	Older people. 3 nursing homes, metropolitan area.	- To identify strategies that older adults use to adapt to live in long term care.	- Grounded theory. - Individual interviews. - Grounded theory method for analysis.	- Purposive sampling. - n=21. - Age range 65-93 years. - Males n=4, Females n=17. - Length of stay 3 days to 9 years and 10 months.	H

Falk et al 2012, Sweden	Older people. 4 residential care homes in city.	- To gain a deeper understanding of the processes involved and the strategies by which older persons create a sense of home, place-attachment and privacy in residential care facilities.	- Constructivist grounded theory. - Individual interviews. - Grounded theory method of analysis. - Informed by the concepts of space and place.	- Purposive and convenient. - n=25. - Mean age 82 years. - Males n=6, Females n=21. - Mean length of stay 9 months.	H
Lee et al, 2013, UK	Older people. 3 residential care homes, North West England.	- To explore qualitatively older people's experiences of transition, including how relocation is reflected upon and incorporated into their personal narratives.	- Qualitative. - Individual interviews. - Narrative analysis.	- Sampling approach not reported. - n=8. - Age range 65-97 years. - Males n=2, Females n=6. - Length of stay 3 to 12 months.	M
Eika et al, 2014, Norway	Staff members. 1 nursing home-rural.	- To describe and explore different nursing staff's actions during the initial transition period for older people into a long-term care facility.	- Constructivist hermeneutical. - Individual interviews, participant observation, documentary analysis. - Thematic analysis.	- Convenience sampling. - n=16- nurses (4), head nurses (1), auxiliaries (6), assistants (5). - Age range 20-30 years.	H
Johnson & Bibbo 2014, USA	Older people. Nursing homes- no. not reported.	- How does the concept of home emerge in older adults who have recently relocated into a nursing home? - To what extent does the concept of home change following the period of potential adjustment? - In what way does the degree of perceived control over the decision making process seem to be related to the sense of home developed in a nursing home?	- Interpretive phenomenology. - Individual interviews. - Phenomenological method of data analysis.	- Random sampling. - n=8. - Age range 68-97 years, mean age 80.88 years. - Males n=4, Females n=4. - Interviewed within the first 2 weeks of admission and then 6-8 weeks after the initial interview.	H
O'Shea et al, 2014, Ireland	Family members. 3 residential care homes.	- To explore relatives' involvement in the care of older adults admitted to residential settings.	- Qualitative. - Individual interviews. - Content thematic analysis.	- Purposive sampling. - n=9. - The identified relationship to the resident was son (4), daughter (3), husband (1) and wife (1).	L

Sussman & Dupuis, 2014, Canada	Older people. 3 LTCFs- public funded.	To investigate: - What conditions help or hinder older adults' positive experiences with each phase of the relocation process including the decision-making phase, the move itself, and the initial post-move adjustment? - How do the presence or absence of conditions from one phase of the process influence residents' experiences with subsequent phases?	- Grounded theory. - Individual interviews. - Interpretive grounded theory approach for analysis.	- Selective purposive sampling. - n=10. - Age range 75-97 years. - Males n=2, Females n=8. - At time of interview had been resident for 4-8 weeks.	H
Ellis & Rawson, 2015, Australia	Staff members. 4 nursing homes- metropolitan and regional Australia.	- To explore, from the perspective of care staff (RNs, ENs and PCAs), their perceptions of relocation processes for older people moving into a nursing home.	- Qualitative. - Individual interviews. - Thematic analysis.	- Convenience sampling. - n= 20- RNs (7), ENs (5), PCAs (8).	M
Altintas et al, 2017, France.	Older people. No of nursing homes not reported.	- To explore the relationship between relatedness, motivation, adaptation and leisure in nursing homes.	- Questionnaire survey using the Nottingham Leisure Questionnaire, the General Need Satisfaction Scale, the Elderly Motivation Scale, and EAPAR to assess adaptation to nursing homes. - Framed using Self-Determination Theory.	- Sampling approach not reported. - n=112. - Males n=20, Females n=92. - Mean age 84.17 years. - Average length of time living in nursing homes 4.59 years.	H
Koppitz et al, 2017, Switzerland	Older adults. 4 nursing homes- urban and rural.	- To gain an in-depth understanding into unplanned admissions to nursing homes and to explore its impact on adaptation.	- Qualitative. - Individual interviews. - Content analysis. - Design informed by Meleis' Transition Theory.	- Purposive sampling. - n=31. - Mean age 83.1 years. - Males n=8, Females n= 23. - Mean length of stay= 26.5 months. - At time of interview length of stay ranged from 1 month to 93 months.	M
Gilmore-Bykovskyi et al, 2017, USA.	Nurses. 11 Skilled Nursing Facilities, urban and rural.	- To describe skilled nursing facility (SNF) nurses' perspectives on the experiences and needs of persons with dementia during hospital to SNF transitions and to identify factors related to the quality of these transitions.	- Qualitative- grounded dimensional analysis. - Individual interviews, n=4, and focus groups. - Constant comparative analysis.	- Purposive sampling. - n=40, practical and licensed (subsample sizes not reported).	H

Table 2 Transition Facilitators and Inhibitors

Theme	**Transition Conditions** ***PC= Personal conditions, CC= Community conditions, SC= Society conditions***	**Contributing Studies**
Resilience of the older person- making sense of and coming to terms with the relocation and the associated gains and losses	***Facilitators***	
	• Self-efficacy (PC)	Johnson et al 1998, Lee 2010
	• Self-determined motivation (PC)	O'Connor & Vallerand, 1994, Curtiss et al, 2007
	• Having a personal philosophy to draw upon to help make sense of their lives, to give meaning to their new situation and to facilitate tolerance and acceptance (PC) e.g. - accepting their fate - living for today rather than dwelling on the past or worrying about tomorrow, having a 'survivor mentality' - having an inner strength - recognising a personal responsibility to make the best of their new situation	Iwasiw et al 1996, Hersch et al 2003 Wu et al 2009 Brandburg et al 2012 Lee et al 2013 Kahn 1999, Johnson & Bibbo 2014
	• Continuing one's faith, one's values, beliefs & personal identity (PC)	Hersch et al 2003
	• Religiosity (PC)	Sasson 2001b
	• Ethnic behaviour- involvement in social groups, cultural practice, food, music and customs of one's ethnic group) (CC)	Sasson 2001a
	• Personal attributes such as being patient, flexible, co-operative, pleasant and positive (PC)	Wilson 1997, Kahn 1999, Hersch et al 2003, Lee 2010, Brandburg et al 2012, Falk et al 2012
	• Coping strategies (PC) such as: - reframing - talking about losses and seeking solutions - using a small steps approach - learning the rules, regulations and routines of the care facility - adopting the culture of their new environment	Porter & Clinton 1992 Brandburg et al 2012 Johnson & Bibbo 2014 Iwasiw et al 1996, Reed & Payton 1997, Lee 1999, Lee et al 2002, Brandburg et al 2012, Sussman & Dupuis 2014 Lee 1999
	Inhibitors	
	• Negative perceptions (PC) e.g. - viewing relocation as being about losses, powerlessness and discontinuity - resignation that living in the care facility was something they had to do	Porter & Clinton 1992, Wilson, 1997, Kahn 1999, Lee 1999, Reed & Morgan 1999, Kydd 2005, Wiersma 2010, Falk et al 2011, Fraher & Coffey 2011, Falk et al 2012, Brandburg et al 2012, Lee et al 2013, Johnson & Bibbo 2014, Ellis & Rawson 2015, Koppitz et al 2017

Theme	Transition Conditions *PC= Personal conditions, CC= Community conditions, SC= Society conditions*	Contributing Studies
Interpersonal Connections and Relationships	***Facilitators***	
Establishing new connections and relationships with co-residents		
	• Perceived emotional support from co-residents (PC)	Lee 2010
	• Having a positive attitude to get along with others (PC)	Lee et al 2002, Brandburg et al 2012, Falk et al 2012
	• Joining buddy groups and taking on advocate and mentor roles to support fellow residents (CC)	Reed & Payton 1997, Lee 1999, Lee et al 2002, Hersch et al 2003
	• Involvement in the relocation decision (PC)	Iwasiw et al 1996
	• Introductions to co-residents by resident mentors (CC)	Reed & Payton 1997
	• Family members actively encouraging and facilitating new social networks (CC)	Sandberg et al 2002, Davies & Nolan 2006
	• Engaging with meaningful activities and events such as exercise, music, games, and religious activities/services (CC)	Iwasiw et al 1996, Hersch et al 2003, Brandburg et al 2012, Falk et al 2012, Sussman & Dupuis 2014, Ellis & Rawson 2015
	• Feeling connected and secure in relationships and part of the facility community (PC)	Altintas et al 2017
	• Consolidation of new social networks with co-residents by reciprocity, with residents helping each other (CC)	Reed & Payton 1997
	• Geography, design and significance of shared spaces (CC)	Falk et al 2012
	Inhibitors	
	• Uninvited/ unwelcomed interactions and residents' lack of insight about social norms and etiquette of communal living (CC)	Reed & Payton 1997, Wilson 1997, Johnson & Bibbo 2014
	• Being opposed to the relocation (PC)	Iwasiw et al 1996
	• Being ageist and having negative views about older people with physical and/or mental health impairments (PC)	Lee et al 2013
	• Lack of staff attention to facilitating introductions and friendships between residents (CC)	Reed & Payton 1997, Davies & Nolan 2006
	• Being positioned by staff to sit beside residents who they did not know or like (CC)	Reed & Payton 1997, Lee et al 2013
	• The care facility not offering activities/ offering activities that residents did not like/ residents not knowing about activities/ residents not being able to participate in activities due to health needs (CC)	Lee 1999, Lee et al 2013, Koppitz et al 2017
	• Geography, design and significance of shared spaces (CC)	Falk et al 2011

Interpersonal connections and relationships with care facility staff	***Facilitators***	
	• Supportive staff, family-like (CC)	Hersch et al 2003, Brandburg et al 2012
	• Staff knowing/making an effort to get to know residents and families (CC)	Eika et al 2014
	• Emotional support from staff (CC)	Lee 2010
	Inhibitors	
	• The geography, design and significance of shared spaces creating feelings of abandonment (CC)	Falk et al 2011
	• Uncaring conversations with staff (CC)	Lee 1999
	• Feeling the need to be co-operative with staff, not to be seen as troublesome, to ask for little, and remain silent about unpleasantries (PC)	Lee et al 2002
	• Organisational factors such as staff workload and time constraints (CC)	Reed & Payton 1997, Ellis & Rawson 2015
Maintaining valued relationships with family, friends and significant others beyond the care facility	***Facilitators***	
	• Continuing to see significant people in person, and/or via letters & technology supported conversations (CC)	Hersch et al 2003, Falk et al 2012, Koppitz et al 2017
	• Being satisfied with their family relationships (PC)	Lee et al 2010
	• Families adopting new roles when the older person relocated (CC) e.g. - using their knowledge of the older person to enhance the quality of the care experience - facilitating communication between the older person and care facility staff - keeping an eye on care delivery to ensure best care - working to enhance and enrich the life of the older person by encouraging continuation of past-times and routines and engaging with new opportunities - sustaining a good parent-child relationship - helping maintain connections and relationships with the wider family and others beyond the care facility	Sandberg et al 2002, Davies & Nolan 2006, Wu et al 2009
	Inhibitors	
	• Influence of cultural beliefs/norms with a distancing from their families in order to 're-establish their lives' (PC)	Lee 2002
	• Disharmony with family members CC)	Lee et al 2002, Hersch et al 2003
	• Loss of self-identity e.g. no longer being seen as part of a couple by adult children (PC)	Sandberg et al 2002
	• Being physically separated from one's partner/spouse (CC)	Sandberg et al 2002, Wiersma 2010

Theme	Transition Conditions *PC= Personal conditions, CC= Community conditions, SC= Society conditions*	Contributing Studies
This is My New Home	***Facilitators***	
	• Being able to create their own space, to have a place they could call their own (CC)	Iwasiw et al 1996, Kahn 1999, Falk et al 2012, Johnson & Bibbo 2014, Sussman & Dupuis 2014
	• Involvement in deciding what personal belongings should be brought from their former residence and arranging these in their new space (CC)	Kahn 1999, Johnson & Bibbo 2014, Sussman & Dupuis 2014
	• Incorporating personal possessions to make their private space useful, comfortable and true to their self-identity (CC)	Sussman & Dupuis 2014, Koppitz et al 2017
	• Having choice and control and able to exercise self-determination about what they did, who they 'invited in' and 'kept out' (PC)	Brandburg et al 2012, Falk et al 2012
	• Transporting themselves mentally to their former home (PC)	Kahn 1999
	• Continuity of values, beliefs and personal identity (PC)	Hersch et al 2003
	• Having privacy for self and co-residents, and respect for privacy and personal space shown by staff and co-residents (CC)	Iwasiw et al 1996, Wilson 1997, Kahn 1999, Curtiss et al 2007, Fraher & Coffey 2011, Sussman & Dupuis 2014
	• Living in close proximity with co-residents and others (CC)	Lee 1999, Lee et al 2002
	• Internal and external design of the care facility enabling older people to pursue hobbies and interests and to experience a sense of calm and peace (CC)	Fraher & Coffey 2011, Ellis & Rawson 2015
	Inhibitors	
	• Not having the opportunity to choose what personal possessions to bring to the care facility (CC)	Johnson & Bibbo 2014
	• Having to limit their choice of personal possessions (CC)	Iwasiw et al 1996, Wilson 1997, Wiersma 2010, Ellis & Rawson 2015, Koppitz et al 2017)
	• Noisy and wandering co-residents (CC)	Ellis & Rawson 2015
	• Staff disregard for privacy by entering a resident's room unannounced (CC)	Sussman & Dupuis 2014
	• Lack of privacy at mealtimes for those needing full assistance; and for those sharing a bedroom, a lack of privacy to receive one's visitors and at critical times such as when a co-resident was ill or dying (CC)	Lee 1999, Fraher & Coffey 2011
	• Staff values and practices, and care facility regulations and processes regarding safety and risk (CC)	Iwasiw et al 1996, Wiersma 2010, Johnson & Bibbo 2014, Sussman & Dupuis 2014, Koppitz et al 2017

Theme	Transition Conditions *PC= Personal conditions, CC= Community conditions, SC= Society conditions*	Contributing Studies
The Care Facility as an Organisation	***Facilitators***	
	• 'Moving in' processes and practices (CC) e.g. - older people feeling that their arrival was expected - designated staff to manage the admission process who were confident and experienced - leadership that emphasised for staff the significance of moving in for older people and their families - being welcomed at the time of admission - orientation processes that included being introduced to staff and co-residents - being made to feel valued as a person	Eika et al 2014, Sussman & Dupuis 2014, Ellis & Rawson 2015
	• Staff knowing and understanding the older person (CC)	Gilmore-Bykovskyi et al 2017
	• Resident satisfaction with the care facility and with the standard of care (PC)	Wu et al 2009, Lee 2010, Lee et al 2013
	Inhibitors	
	• Unsatisfactory moving in practices (CC) e.g. - the care facility having no control over arrival time so that an older person arrived at a particularly busy time - staff adopting a business as usual approach - admission being viewed as a process of paperwork and tasks and less about the older person	Wiersma 2010, Eika et al 2014
	• Approaches to care (CC) e.g.: - promoting dependence rather than self-management, with staff not valuing a philosophy of self-care and not considering it a priority to spend time encouraging self-care - a task focused approach that did not consider the individual preferences of the older person and the uniqueness of the older person - ad-hoc approaches to staff acquiring and sharing knowledge about residents, handover reports that were too short, staff not valuing regular updated written information about residents	Wiersma 2010, Sandberg et al 2012, Eika et al 2014
	• Organisational constraints (CC) e.g. - inadequate staffing levels that resulted in care delivery being hurried, delays in staff responding to residents' calls for assistance and a lack of time for staff to talk with residents	Wiersma 2010, Lee et al 2013, Ellis & Rawson 2015
	• Care facility rules, regulations and routines: (CC) - over-emphasis on safety and risk minimisation - expectation that older people will conform with staff expectations - a greater focus on organisational needs rather than individual resident needs	Iwasiw et al 1996, Wiersma 2010, Eika et al 2014, Sussman & Dupuis 2014, Koppitz et al 2017